STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	04/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH NURSING HOME	701 S OAK STREET WINCHESTER, IN47394

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/25/11 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Randolph Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 88 and had a census of 74 at the time of this visit.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 14 residents who reside on the 300 Hall. Findings include:	K0027	K027 **Please accepti tihis plan of correction as our credible allegation of compliance witih all regulatiory requirementis** Correcttve actton ftor aftectted residentt Itt is tthe inttentt oft tthis ftacilitty tto ensure swinging doors are arranged so tthatt each door shall be selftclosing and lattch The 300 wing sett oft doors were repaired on April 25, 2011 tto close and lattch as required. Identttftcatton oft otther residentts att	05/11/2011

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	Based on observation on 04/25/11 at 10:45 a.m. with the maintenance supervisor, the 300 Hall set of smoke barrier doors next to the therapy room had a two foot gap where the south door in the set dragged on the floor on two separate attempts to close the smoke barrier doors. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)		risk; All setts oft ftre doors have been ttestted tto ensure tthatt each door closes and lattches as required Measures tto ensure tthis deftcientt practtce does nott recur Mainttenance sttaft has been re-educatted tto ftederal regulatton K27. All ftre doors will be placed on a preventtve mainttenance program ensuring all ftre doors close and lattch as required (see ftorm Attachmentt A) Monittoring oft correcttve acttgn All ftre doors will be placed on a preventtve mainttenance program ensuring all ftre doors close and lattch as required(see ftorm Attachmentt A). The mainttenance supervisor or his designee will review each smoke barrier door using ftorm Attachmentt A as partt oft Randolph's Qualitty Assurance Program, ensuring tthe LSC requirementt tthatt each door closes and lattches as required	
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview, the facility failed to ensure 1 of 1 battery backup lights was tested at 30 day intervals and annually for a 90 minute duration to ensure the light would provide lighting during periods of power outages	K0046	K046 **Please accepti tihis plan of correction as our credible allegation of compliance witih all regulatiory requirementis** Correcttve actton ftor aftectted residentt	05/11/2011

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	to protect any resident using the main dining room. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any residents who use the main dining room. Findings include: Based on an interview on 04/25/11 at 9:40 a.m. with the maintenance supervisor, the facility has one battery backup light located in the main dining room. Based on a review of the Preventive Maintenance Log Book and the Fire Drill Log book, there was no evidence the battery powered backup light was tested at thirty day intervals for 30 seconds, or annually for a ninety minute duration. This was verified by the maintenance supervisor at the time of record review. 3.1-19(b)		Itt Is tthe inttentt oft tthis ftacilitty tto provide emergency lighttng oft att leastt1 ½ hr duratton. The battery back up lightt locatted in tthe Main Dining Room has been removed. Lighttng in tthe Main Dining room had been added tto tthe generattor battery back up lightt is nott needed Identttftcatton oft otther residentts att risk; Itt Is tthe inttentt oft tthis ftacilitty tto provide emergency lighttng oft att leastt1 ½ hr duratton. The battery back up lightt locatted in tthe Main Dining Room has been removed. Lighttng in tthe Main Dining room had been added tto tthe generattor battery back up lightt is nott needed Measures tto ensure tthis deftcientt practtce does nott recur Itt Is tthe inttentt oft tthis ftacilitty tto provide emergency lighttng oft att leastt1 ½ hr duratton. The battery back up lightt locatted in tthe Main Dining Room has been removed. Lighttng in tthe Main Dining room had been added tto tthe generattor battery back up lightt is nott needed Monittoring oft correcttve acttgn Itt Is tthe inttentt oft tthis ftacilitty tto provide emergency lighttng oft att leastt1 ½ hr duratton. The battery back up lightt locatted in tthe Main Dining Room has been removed. Lighttng in tthe Main Dining room had been added tto tthe generattor	

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K0047 SS=E	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 12 illuminated exit and directional signs was provided with continuous illumination. This deficient practice could affect 14 residents who reside on the 300 Hall near the therapy room. Findings include: Based on observation on 04/25/11 at 10:35 a.m. with the maintenance supervisor, the 300 Hall exit and directional sign above the exit door across from the therapy room was not illuminated. Based on an interview with the maintenance supervisor on 04/25/11 at 10:40 a.m., the exit and directional sign has a burned out light bulb. 3.1-19(b)	K0047	battery back up lightt is nott needed K047 **Please accepti tihis plan of correction as our credible allegation of compliance witih all regulatiory requirementis** Correcttve actton ftor aftectted residentt Itt is tthe inttentt oft tthis ftacilitty tto ensure all exitt and directtonal signs are displayed witth conttnuous illuminatton. On April 25, 2011, tthe lightt bulb tto tthe exitt sign locatted on tthe 300hall was replaced, tthe exitt sign proved tto be in working order providing illuminatton. Identttftcatton oft otther residentts att risk; All setts oft exitt and directtonal signs were reviewed and proved tto be in working order. Measures tto ensure tthis deftcientt practtce does nott recur Mainttenance sttaft has been re-educatted tto ftederal regulatton K47. All exitt and directtonal signs will be placed on a preventtve mainttenance program ensuring exitt and directtonal signs have conttnuous illuminatton. Monittoring oft correcttve acttgn All exitt and directtonal signs will be	05/11/2011

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			placed on a preventtve mainttenance program ensuring all exitt and directtonal signs have conttnuous illuminatton (see ftorm attachmentt B). The mainttenance supervisor or his designee will review each exitt and directtonal signs using (see ftorm Attachmentt B) as partt oft Randolph's Qualitty Assurance Program, ensuring tthe LSC requirementt tthatt each exitt and directtonal signs have conttnuous illuminatton.	
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift for 3 of 4 quarters during the past year to protect 74 of 74 residents. This deficient practice affects all residents in the facility. Findings include: Based on a review of the Fire Drill Log book with the maintenance supervisor on 04/25/11 at 9:00 a.m., there was no record of a fire drill conducted for the third shift, first quarter of the year 2011; second or	K0050	K50 Corrective action for affected resident; It is the intent of this facility to hold fire drills at unexpected times under varying conditions at least quarterly on each shift. A Fire Drill was conducted on April 13, 2011/first shift and May 10, 2011/third shift, Quarter II for the year 2011. Identification of other residents at risk; Maintenance staff has been re-educated to federal regulation K50. A Fire Drill was conducted on April 13, 2011/first shift and May 10, 2011/third shift, Quarter II for the year 2011.Measures to ensure	05/11/2011

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	third shift for the third quarter of the year 2010; and the first shift, second quarter of the year 2010. Based on an interview with the maintenance supervisor on 04/25/11 at 9:25 a.m., and after a fifteen minute review of the Fire Drill Log book, the maintenance supervisor indicated there was no other documentation available for review to verify a third shift fire drill for the first quarter of 2011, a second and third shift fire drill for the third quarter of 2010, and a first shift fire drill for the second quarter of 2010. 3.1-19(b)		this deficient practice does not recur; Maintenance staff has been re-educated to federal regulation K50. A Fire Drill was conducted on April 13, 2011/first shift and May 10, 2011/third shift, Quarter II for the year 2011.Monitoring of corrective action; Maintenance staff has been re-educated to federal regulation K50. A Fire Drill was conducted on April 13, 2011/first shift and May 10, 2011/third shift, Quarter II for the year 2011. Form (Attachment C) has been initiated to assist in conducting fire drills at unexpected times, under varying conditions, at least quarterly each shift. Form (Attachment C) will become part of Randolph's Quality Assurance Program, ensuring the LSC requirement of conducting fire drills at unexpected times, under varying conditions, at least quarterly each shift.	
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen	K0076	K076 Correcttve actton ftor aftectted residentt Itt is tthe inttentt oft tthis ftacilitty tto mainttain a minimum disttance oft 5ft	05/11/2011

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	containers in 1 of 1 oxygen storage areas. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect 14 resident who reside on the 300 Hall near the oxygen storage room. Findings include: Based on observation on 04/25/11 at 11:15 a.m. with the maintenance supervisor, the 300 Hall oxygen storage room had three full liquid oxygen containers stored within one foot of eight shelves of combustible plastic oxygen supplies stored in cardboard boxes. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)		bettween liquid oxygen and combusttble matterial All combusttble matterial has been removed ftrom tthe 300 hall oxygen sttorage room Identtftcatton oft otther residentts att risk; All combusttble matterial has been removed ftrom tthe 300 hall oxygen sttorage room There is no otther oxygen sttorage room in tthe ftacilitty Measures tto ensure tthis deftcientt practtce does nott recur All combusttble matterial has been removed ftrom tthe 300 hall oxygen sttorage room There is no otther oxygen sttorage room in tthe ftacilitty Maintttenance and Housekeeping sttaft will be reeducatted tto Lifte Saftetty Code 7.6. Form (Attachmentt D) will be incorporatted intto tthe Housekeeping Departtmentt daily schedule tto ensure a minimum disttance off 5ft bettween liquid oxygen and combusttble matterial is mainttained Form (Attachmentt D) will become partt oft Randolph's Qualitty Assurance Program, ensuring tthe LSC requirementt oft a minimum oft 5ft bettween liquid oxygen and combusttble matterial is mainttained Monittoring oft correcttve acttgn All combusttble matterial has been removed ftrom tthe 300 hall oxygen sttorage room There is no otther oxygen sttorage room in tthe ftacilitty	

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			Form (Attachmentt D) will be incorporatted intto tthe Housekeeping Departtmentt daily schedule tto ensure a minimum disttance off 5ft bettween liquid oxygen and combusttble matterial is mainttained. Form (Attachmentt D) will become partt oft Randolph's Quality Assurance Program, ensuring tthe LSC requirementt oft a minimum off 5ft bettween liquid oxygen and combusttble matterial is mainttained.	